Israel has withstood the test of time. It continues to be a beacon for the faithful and now welcomes 380 families inside its walls.

The story of Mickve Israel is special to the people and has been recognized for its achievement since its early years. President George Washington sent a personal letter to the congregation to honor its members and wish them well.

Since then, numerous Presidents over the years have made similar gestures, each one acknowledging the congregation's longevity and importance to the Jewish community.

I would also like to acknowledge the congregation's importance and congratulate Congregation Mickve Israel in reaching this impressive milestone. I know this religious community will continue to serve a caring, faithful, and integral role in Savannah, Georgia.

□ 1645

OPIOID ADDICTION CRISIS

The SPEAKER pro tempore. Under the Speaker's announced policy of January 3, 2017, the gentleman from Pennsylvania (Mr. MURPHY) is recognized for 60 minutes as the designee of the majority leader.

Mr. MURPHY of Pennsylvania. Mr. Speaker, tonight, I am joined by a number of Members here to talk about one of the most insidious problems our Nation has faced in a long time. It is the problem of opioid abuse. We are in a crisis mode.

We have now reached a point where we will have more deaths from drug overdoses this year than there are names on the Vietnam Veterans Memorial Wall in Washington. That is a frightening concept.

There is almost no county, no State in America, that is not affected by this. Some areas have much more. Places in eastern Kentucky, southern West Virginia and up the Ohio Valley, and places in New England and out West have seen this as a growing problem as death rates rise.

There are things we can do about this. But in order to have some discussion of what we can do about this, we are going to talk about how we got to this problem and then what we can do to go beyond that.

I want to start off by yielding to the gentleman from Oregon (Mr. WALDEN), the chairman of the Energy and Commerce Committee, to talk about what this means in one State alone, the State of Oregon.

Mr. WALDEN. I thank the gentleman, who chairs our Oversight and Investigations Subcommittee and is so passionate in not only finding a solution to the opioid epidemic, but also his great work on mental health reform as well, as was passed into law in the 21st Century Cures legislation.

As you know, the year before, the Energy and Commerce Committee also passed legislation to begin to address this issue. We will be doing a lot of work, going forward, to look at what is working on the ground and what is not.

Addiction, as you well know from your clinical experience, is an equal opportunity destroyer. It is a crisis that doesn't pick parties. It doesn't pick people because of their race, age, or socioeconomic status. We all know someone impacted by the opioid epidemic. It has literally touched every corner of our country and every community in our States.

The epidemic has hit close to home in my home State of Oregon, where more people now die from drug overdoses than from deaths in automobile accidents. I have met with community leaders, first responders, doctors, police officers, patients, and those on the front lines of this fight against opioid addiction.

At roundtables throughout the Second District of Oregon, I have heard firsthand accounts of the impact of the opioid epidemic. It didn't matter if I was in a rural eastern Oregon community or a more populated city in southern Oregon. The tragic stories were all too similar and all too familiar.

Medical professionals across Oregon told me about the rapid acceleration of the opioid epidemic over the last 20 years. They have witnessed patient after patient fall into the traps of addiction.

I heard from Oregonians who have struggled with the epidemic themselves. At our roundtable, a woman in Hermiston talked about how she became addicted to painkillers. After a minor foot injury, she got a prescription for an opioid-based painkiller. In her decades-long battle with this addiction—trying to get off of this addiction—she was forced to travel more than 5 hours into Washington State just to find a provider who could help her with Suboxone and get off of her addiction. There was nobody locally who could help her.

I heard from a father whose son was a high school athlete. He was prescribed opioids after a sports injury. Tragically, he became addicted. Soon, he transitioned to what we know as a cheaper and more deadly version of the drug known as heroin.

Sadly, this young man would not survive his addiction. He died from heroin. It devastated the family and stole another American in the prime of his life. This story is repeated all too often.

Combating the opioid epidemic in Oregon and every State of the union is going to require a real bipartisan team effort to continue, from elected officials with the input from healthcare experts and those on the front line of this fight in our local communities.

In the Energy and Commerce Committee, we stand shoulder-to-shoulder, all of us together, saying: What can we do more to help in this crisis; to seize the opportunity before us; to look at the legislation that was enacted in the last Congress to make sure that the grants are getting to the ground, as they are in my State; and that we are getting the help and that it is actually working?

It is one thing to pass a bill. It is another to make sure it is implemented correctly and that it actually works effectively.

I commend my colleague from Pennsylvania, Chairman MURPHY, for the work that he is doing on this and the compassion he has for those families who are tragically caught up in this addiction. Together, we are going to find our way through it.

Mr. MURPHY of Pennsylvania. I thank the chairman for his passion and hard work on the Energy and Commerce Committee. We know this is a life-and-death issue. This is one of those things where Members are coming together from both sides of the aisle to deal with.

Let me lay out the background here. How did we get here?

About 80 percent of addictions begin with a prescription. When we see what has happened here on this chart of heroin increased use and prescription opioids, there is something that occurred at the beginning of this millennium where things really began to take off.

On this next poster, seeing here how this is increasing at such a rate—about 9 or 10 percent—it is understandable you are looking at some of these rates increasing severalfold just in the last decade, with increasing jumps. As fentanyl has gotten here, it is even worse.

Back in 1980, Dr. Hershel Jick, a Boston doctor, wrote a letter in The New England Journal of Medicine, and he said this: ''Out of nearly 40,000 patients given powerful pain drugs in a Boston hospital, only four addictions were documented.'' Since he published that letter, it has been cited again about 600 times. Doctors, academics, pharmaceutical companies, and others use it as evidence of the unlikeliness of developing addiction.

But it has been criticized soundly, saying that never should have been said. In fact, The New England Journal of Medicine took the unusual step of posting a one-sentence warning over the so-called Porter and Jick letter to the editor that the Journal published in 1980, and it says: ''For reasons of public health, readers should be aware that this letter has been heavily and uncritically cited as evidence that addiction is rare with opioid therapy.''

Accompanying this note was an analysis from Canadian researchers exploring the frequency the letter had been cited, which was almost 600 times.

Here is the tragedy of this. Many physicians and many pharmaceutical companies said: See, prescribe these opioids; people will be okay. That was found not to be the case.

Jump ahead to 2001, when The Joint Commission released their pain management standards, and then shortly after that the American Medical Association said: let's make pain one of the

vital signs. The other vital signs being blood pressure, heart rate, respiratory rate, and temperature. But when pain was also made one of those as well, doctors began asking questions about that, and basically screening people along the lines of: On a scale of 1 to 10, what is your pain level?

Everything else is measured with an instrument objectively, but pain is subjective. In fact, it is so subjective that it was found that 51 percent of people who are on an opioid have a mood disorder, such as depression or anxiety. There is a huge amount there.

The thing about this, if a person fails to screen for presence of a mood disorder, along with other aspects, you really increase their risk for addiction.

About 50 million Americans, for example, have low back pain. Twenty-five million of those are on an opioid. Of that group, about 40 percent have been found to have depression. If you combine depression and opioid use, you could triple or quadruple your risk for misuse, abuse, and addiction. It would make sense that before a doctor prescribes in these cases, concurrently they would also be screening for mood disorders. That does not appear to be the case.

Here is another part of the problem. Under the Affordable Care Act, hospital payments are tied to patient pain satisfaction surveys, which reward hospitals financially when patients give them a high rating for managing pain. In turn, the hospitals get less money if the patient says: my pain was not handled.

That is actually question 14 of the Hospital Consumer Assessment of Healthcare Providers and Systems survey. It asks the question: How often did the hospital or provider do everything in their power to control your pain? Doctors feared negative responses, as did many hospitals, and it was found that probably had an impact on increasing prescriptions.

Another part of the problem is treatment access. Quite frankly, if you want to get help, you can't find it. Unfortunately, getting access to high-quality treatment is unlikely in the United States. Of the 27 million Americans suffering from addiction, less than 1 percent receive evidence-based treatment.

We have a shortage of trained providers, and half the counties in America have no psychologists, no psychiatrists, and no clinical social workers.

Let me add to this also that medication-assisted treatment is one of those things put up here as a treatment method. If I show you here, medication-assisted treatment is when a person is replacing their illegal drug with something like methadone or Suboxone, which Chairman WALDEN just referred to.

But here is part of the problem. It is supposed to be the doctor writing the prescription and then the patient is getting other treatment. But as is found with medication-assisted treatment, just in Pennsylvania alone, nearly 60 percent had no counseling in the year they received the buprenorphine. Forty percent were not drug-tested in the year they received the buprenorphine.

This is important because a person may receive a prescription but still remain on heroin or another drug. Thirty-three percent have between two to five different prescribers writing them a prescription for this. Where do all those prescriptions go?

This is one of the top diverted drugs. Many times, the patients simply take those drugs, sell them, and buy the street drugs. Twenty-four percent of those buprenorphine prescriptions didn't see a physician in the prior 30 days.

In other words, with medication-assisted treatment, we simply have a failure to provide other treatment and a low expectation for improvement, in many cases thinking we will replace one addiction with another.

Another part is in the area of hospital care. When treating opioid and heroin addiction, inpatient and residential treatment is crucial for full recovery, but there are simply not enough treatment centers and beds. Today, our Nation suffers a shortage of 100,000 inpatient treatment beds.

Further, we don't have enough providers. When we do have providers, many times they end up overprescribing.

There was a law in the United States back in the Nixon era called 42 C.F.R., consolidated federal registry. Basically, it made it so that physicians could not find out in the record if a patient was on other opioids, in treatment for that, or taking buprenorphine or methadone.

So what happened? Someone shows up in the emergency room, they are in pain, perhaps a doctor looks in the record and doesn't see anything there, and writes a prescription. If that person was in treatment and was recovering from an addiction, and at that point not taking other drugs, look at what just happened. The doctor may prescribe some opioids for that patient who was used to taking quite a few at any given time to have an effect. Now they have this, and they are no longer thinking: I will take just one or two. They may take more. So you risk overdose.

The second thing you do is risk a relapse. That person was perhaps clean for months or years. Now they have OxyContin or some other opioid, they take it, and they have a relapse.

But there is a third problem that goes with that, and that is the person may be on other drugs, such as benzodiazepines or other respiratory suppressants, and that becomes a problem because then the doctor doesn't know about drug interactions.

So we have this law in place which prohibits sharing of information about substance abuse treatment between doctors. Doctors unknowingly prescribe these for people. It causes more problems. We need to deal with this.

Another level here is fentanyl. Fentanyl is a synthetic opioid which is a staggering 50 times more potent than heroin and 100 times more potent than morphine. It has a high potential for abuse. A mere 2 milligrams is fatal. A single packet of sweetener for your coffee is 1,000 milligrams. Take two of those and that is enough to kill you.

Since last 2013, fentanyl has contributed to at least 5,000 overdose deaths in the U.S., and that is soaring. However, due to gaps in the data collections, it is likely the number of overdose deaths in the U.S. is actually much higher.

A low-cost, high-profit, hard-to-detect profile of fentanyl is increasingly more trafficked to traffickers and relatively easy to manufacture. China is a major part of this, in that the illegally manufactured fentanyl shipped to the U.S. via labs in Mexico, smuggled across the border, then hits our streets.

One other thing I want to point out here, in terms of this problem. If we look at what some have analyzed in terms of areas that are hotspots for substance abuse, you can see in here for persons on disability, look at the sections in Kentucky, West Virginia, Virginia, along the Mississippi Valley, up the Ohio Valley, and parts out West. This isn't the only causal factor. Many times you have people on disability and pain, and what happens is they may be prescribed opioids as part of that.

When you look here, where age-adjusted death rates occur for drug poisoning—those overdose deaths—look at the hotspots in America. It is just about the same out here in the Mississippi-Ohio Valley, portions out West, where you have these problems.

All of these come together in terms of crime, in terms of drug cartels, in terms of fentanyl, in terms of poor access to treatment.

I mentioned the hospital beds. By the way, over half the counties in America have no psychiatrist, no psychologist, no social worker, and no licensed drug treatment provider.

□ 1700

It is no wonder we are in this mess. We will talk more about some solutions here, but I wanted to recognize a number of Members who might want to talk about this.

Let me first go to the gentleman from Georgia (Mr. CARTER). Representative CARTER is also a pharmacist. Let's hear some of his perspective.

Mr. Speaker, I yield to the gentleman from Georgia (Mr. CARTER).

Mr. CARTER of Georgia. Mr. Speaker, I thank the gentleman for yielding, and I thank the gentleman for hosting this Special Order.

This is certainly a very important subject, one that I am very familiar with. It is indeed an epidemic in our country. There is not a State nor a district that hasn't been touched by this problem. Countless people have succumbed to this issue. That issue is the

use of opioids and the devastating impact on our communities.

Recent data showed that overdose deaths have jumped by over 50 percent in the decade leading up to 2015. In addition, nearly 1,300 people died in Georgia in 2015 from drug overdoses. These are statistics that need to be urgently addressed. We have made great progress with the passage of the Comprehensive Addiction and Recovery Act, but we have an opportunity to do more.

One staggering statistic is that last year it is estimated that roughly 60,000 people died from drug overdoses—a number that is far too high. Just earlier this month, four people in central Georgia died in a matter of 2 days due to opioid overdoses from falsely labeled drugs. That instance is not only troubling because it reflects growing painkiller use in the rural parts of my State, but because it also represents another problem: counterfeit and fake drugs.

An issue that I have been working on is the growing trend of drugs and drug ingredients being ordered abroad and delivered through the mail to addresses around the country.

A recent Wall Street Journal article mentioned the synthetic opioids that are being brought into this country and the methods by which they are doing it.

An example of one of those drugs is fentanyl, a synthetic opioid that is wreaking havoc across the country.

We must not only look at the types of drugs that are being used, but also how people are acquiring them and how to effectively limit that. Our enforcement personnel are working diligently with the Postal Service to find ways to curb this trend, such as using advanced data. But it is a topic that needs more work. By cutting off their ability to purchase these dangerous synthetic opioids, we can help to limit this epidemic.

As a lifelong pharmacist, I have seen firsthand the dangers and problems associated with opioid abuse and its impact on our communities. I look forward to working with my colleagues on both sides of the aisle to counter this trend in hopes of saving lives.

Again, I want to thank the gentleman for hosting this tonight. It is so very vital to our country. Thank you for allowing me to speak.

Mr. MURPHY of Pennsylvania. As a pharmacist, when people come into the pharmacy, for example, if they want to get Sudafed, a cold medication, they have to go through some special process. It is behind counter. Is that right?

Mr. CARTER of Georgia. That is correct.

Mr. MURPHY of Pennsylvania. Now, what if they wanted to pick up an opioid prescription? Do they have to show an ID? Are they required by law to have the same kind of restrictions?

Mr. CARTER of Georgia. Yes, they are. They have to show an ID in order to pick it up. Now, the prescription itself is a C2 prescription, so if we don't recognize them at the pharmacy, we have to ask them for their ID to make sure that is indeed the person who is picking it up.

We also have a program in Georgia, in fact, a program that you are very familiar with, a prescription drug monitoring program, that allows us to go and check a database to see if that person has actually been doctor shopping or is pharmacy shopping and getting it at other places. That has helped us. It is a great tool in fighting this epidemic.

Mr. MURPHY of Pennsylvania. But as the gentleman knows, that is data within the State, but across State lines, that data is still not populated.

Mr. CARTER of Georgia. That is one of the major problems. For instance, in my practice, I practiced in Savannah, Georgia, which is on the South Carolina line, and only 2 hours from the Florida State line. That was a constant problem for us. I could look at my data all day long, but I wouldn't know whether they had gotten something filled in South Carolina or in Florida.

Mr. MURPHY of Pennsylvania. I appreciate that. That is a problem we are going to have to fix in our committee.

I want to call up the gentleman from Ohio (Mr. JOHNSON), eastern Ohio. Speaking of being able to jump across State lines and have prescriptions filled, minutes away from the Pennsylvania/West Virginia border, could travel down there, and also part of that deadly area along the Ohio Valley where so much of this is occurring.

Mr. Speaker, I yield to Mr. JOHNSON.

Mr. JOHNSON of Ohio. I want to thank my colleague, Representative MURPHY, for holding this Special Order on such a critically important topic.

And you mention that my district borders the State of Pennsylvania, and it does. And I have had so many incidents of engagement with my constituents on the opioid addiction issue. Several of them really stick out.

Representative MURPHY, one of those happened in Pennsylvania. Occasionally, because my district goes all the way up to the top into northeast Ohio, occasionally I fly in and out of Pennsylvania. I was there a couple of years ago, and I was sitting in the lounge waiting for a flight. I happened to be on a phone call, and I noticed that a gentleman began to look my direction. He very patiently waited until I got off the telephone, and then he came over, introduced himself. He recognized me, and he said: I am not one of your constituents, but I know that you represent a district just across the border in Ohio. He said: But I want to implore you, to beg you and your colleagues in Congress, please do something about the opioid addiction. He said: Our 21-year-old son died of an overdose in January. He had just gotten out of a rehab, was doing well, had gotten a job. He came home one Friday night, said he was going out with some friends. The next morning his mother and I found him dead in his room.

I hear stories like that all of the time.

I can tell you that the opioid addiction epidemic that is streaking across our country is not one that we are going to be able to arrest our way out of. It is not one that we are going to be able to incarcerate our way out of. It is an issue, my dear colleagues, that is going to take everybody from the top to the bottom, from the President of the United States all the way down to the family members. I am talking about local government officials, law enforcement, the judiciary, faith-based organizations, community organizations. This is something we are going to have to all be engaged in.

We have appropriated, as you know, Representative MURPHY, hundreds of millions of dollars, billions, in fact, to attack the opioid epidemic. More is needed. We are not going to be able to simply throw money at this problem. It is going to require a cultural change within our country.

I have so many other stories, but I don't want to take up more time because I know I have other colleagues here who want to testify on this very important issue.

Just know that I am with you. We take this issue very seriously in our district. Back in Ohio, we are constantly reaching out to law enforcement, mental health providers, healthcare providers, faith- and community-based organizations, and families on how to attack this problem.

I thank you for giving me a chance to speak on it.

Mr. MURPHY of Pennsylvania. I thank the gentleman from Ohio.

I want to next recognize the gentleman from Indiana (Mr. BUCSHON). Certainly he sees this issue, too. As I mentioned before, one of the problems physicians have, if they do not know what kind of prescriptions that person is on, for example, a medical record may show if a person has an allergy to penicillin or something, but you may have no idea that that patient may, for example, be taking buprenorphine or methadone unless they tell you or you test for it. And as a surgeon, what happens when they go to get anesthesia and the complications come from that, but it is part of the reasons why we have to make sure that you as a physician have access to these records, things we can clean up.

Mr. Speaker, I yield to the gentleman from Indiana (Mr. BUCSHON).

Mr. BUCSHON. Thank you, Mr. Chairman. Thank you for holding this Special Order tonight to talk about this really important subject on behalf of the American people.

The opioid abuse disorder and drug addiction have impacted every community in our Nation. The epidemic knows know boundaries; does not discriminate based on age, gender, or socioeconomic status.

According to the Centers for Disease Control and Prevention, 91 American lives are lost every day from an opioid

abuse overdose. Unfortunately, drug overdoses in Indiana have increased fivefold over the past decade, and southern Indiana and the Wabash Valley, the area I represent, are bearing the brunt of this devastation.

This year in Vigo County, Indiana, population around 108,000 citizens, authorities have responded to over 16 opioid- or heroin-induced overdoses already this year.

Vanderburgh County, Indiana, 182,000 citizens, saw 29 deaths from overdose in 2016, which is a fourfold increase from the prior year. This year, the county has seen 25 confirmed heroin- or fentanyl-related overdoses already, but the coroner thinks it may be more.

Just this month, we have seen reports of instances of an opioid-based drug called gray death in Evansville, Indiana.

We are working here in Congress with our States and local communities to finally bring relief to these families, but a lot of work has to be done. While we still have much to do, over the past couple of years, we have actually made significant progress to bring hope to our communities and expand access to treatment for those who need it.

I was proud to be part of our efforts that we put into law, the landmark legislation, the Comprehensive Addiction and Recovery Act, or CARA, and I had the opportunity to author a portion of CARA that expanded access to medication-assisted opioid use disorder treatment, ensure patients have wider access to more comprehensive-based treatment options, and helped minimize the potential for diversion.

As Congressman MURPHY mentioned, the key here is ongoing therapy, counseling, and monitoring. Medication-assisted treatment is not a panacea, but it is a component of a more comprehensive treatment plan for each individual.

Through our work in implementing the 21st Century Cures Act, Congress has provided significant funding for the States. In fact, Indiana recently was granted nearly $11 million from the Department of Health and Human Services to help us with this epidemic.

Again, most of us know someone, a family member, a friend, a neighbor, who has been impacted by this epidemic in some way. As a physician, I have seen the power of addiction up close and have focused on shaping real policy solutions here in Washington, D.C., to improve access to treatment for patients who are battling their problem every day. We all share in this fight, and we can't end this epidemic through policy changes alone. It is ongoing, and it is going to take all of us working together as a community to meet this challenge.

In that respect, I have met with and have been working with people who represent medical schools and residency programs in our country to help better educate the physician on prescribing habits as it relates to pain, whether that is surgical pain or chronic pain. It is a multifaceted approach, and I commend Congressman MURPHY for his dedication to helping end this crisis in our country, and I thank him for yielding.

Mr. MURPHY of Pennsylvania. I thank the gentleman for his impassioned words and dedication here.

I want to refer back to my map here a moment. Dr. BUCSHON was referring to his district in southern Indiana here, which, on this 2014 map, was already showing high mortality rates for those who have drug overdoses.

Look here in the State of Washington, also an area that, on this 2014 map, showed a lot of problems, and now the problem is getting worse.

Mr. Speaker, I yield to the gentleman from Washington (Mr. NEWHOUSE) to speak on this issue.

□ 1715

Mr. NEWHOUSE. Mr. Speaker, I thank the gentleman from Pennsylvania for his leadership on this important issue and for the opportunity to address the House on this very important topic.

Mr. Speaker, as you have heard, our Nation is facing an epidemic. Over the past two decades, opioid overdoses have quadrupled. Think about that. They have quadrupled in the United States. My home State, as Dr. Murphy has just mentioned, has faced significant increases in drug overdose death rates, including a 70 percent increase in synthetic opioid overdose deaths in just the last 10 years. It is clear that this is a crisis, which is why we in Congress are committed to combating this growing epidemic.

Late last year, Congress passed sweeping legislation, called the 21st Century Cures Act. It was bipartisan legislation that authorized $6.3 billion in funding to bring our healthcare innovation infrastructure into the 21st century. This legislation included $1 billion for opioid intervention and prevention treatment programs throughout all 50 States. Earlier this spring, the Federal Government began awarding grants in order to confront this crisis, including $11.7 million to the State of Washington.

While these funds will help expand treatment options, there is still much more work to be done at the Federal level, which is why I cosponsored legislation like H.R. 1057, the Synthetics Trafficking and Overdose Prevention, or STOP, Act. Designed to stop dangerous synthetic drugs like fentanyl, which you heard about, and carfentanil from being shipped through our borders, this legislation will combat bad actors from China and India who have been taking advantage of weaknesses in international mail security standards to break U.S. customs laws and really wreak havoc on our communities.

This is just one step of the opioid crisis that we must address. We need to combat the illicit drugs coming into this country as well as equip doctors, nurses, and first responders with the resources they need to treat pain appropriately.

We also need to support better access to care for individuals suffering from psychiatric and substance abuse disorders. And, most importantly, we must ensure these drugs are not falling into the hands of our Nation's children.

My colleagues in Congress and I are committed to combating this epidemic to keep it from causing further harm to our Nation's families and communities.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I appreciate the gentleman's comments and his dedication to helping his State of Washington.

Mr. Speaker, I yield to the gentleman from Pennsylvania (Mr. ROTHFUS), whose district is just north of Pittsburgh, Pennsylvania, to talk about some of the problems, in his experience, and his thoughts about what we should be doing about substance abuse.

Mr. ROTHFUS. Mr. Speaker, I thank the gentleman for yielding, and I thank him for his long work in this field, not just the last 2 years but, really, a lifetime in this space. I commend him for that work. Also, with mental health issues, he has been helping educate Congress about moving toward solutions.

My colleague has outlined the scope of the national problem we have, and each of us can talk about our respective districts and what has been going on there.

In my district, just over the border from my colleague's, western Pennsylvania has been especially hard hit. In Beaver County, we saw 102 overdose deaths related to opioids in 2016, up from 30 in 2013. In Cambria County, we lost 94 people to overdose deaths in 2016, a startling 62 percent increase from 2015.

The stories just keep coming. A story of the mother who lost her 10th child, her youngest child, to this epidemic, who insisted that the words ''damn heroin'' be put in her son's obituary. Or the couple we learned about before Christmas, who overdosed, and 3 days later their infant died from neglect, all three being found 4 days after that.

Mr. Speaker, it is all hands on deck to address this crisis. We are coming together at the Federal, State, and community level to develop a comprehensive strategy to stop this epidemic and to share best practices at every level. That is what a big part of our Comprehensive Addiction and Recovery Act, passed last year, was all about—an important first step.

Another asset we have, Mr. Speaker, is the Office of National Drug Control Policy. This week, I led a bipartisan group of my colleagues, in a letter to President Trump requesting that the Director of the Office of National Drug Control Policy be re-elevated to a Cabinet-level position.

Since its inception, this Office has played a central and critical role in fighting drug trafficking and drug addiction. Both the Office of National

Drug Control Policy and its Director have played, and should continue to play, a central role in this effort.

The Office was created in 1988 with the Anti-Drug Abuse Act. Its mission is to fight the Nation's drug problem through three areas: prevention, addiction recovery, and enforcement.

The Office's Director, commonly referred to as the ''drug czar,'' was elevated to the Cabinet in 1993 by President Clinton, who wanted to raise the Office's profile in order to coordinate and emphasize legislative efforts on the Hill. More importantly, he wanted to focus and emphasize efforts within the administration for the antidrug efforts of the Department of Justice, the Drug Enforcement Administration, the Department of Education, and the Department of Health and Human Services. The Obama administration removed the Office from the position it had in the Cabinet.

When it comes to drug addiction as well as to the illicit drug trade occurring across our southern border, the challenges have never been greater. This is no time to retreat in our efforts, and it is time to restore the Office of National Drug Control Policy to the Cabinet.

The Office is a very important part of the fight against the opioid epidemic, particularly because it plays a crucial role in coordinating efforts at various levels of government. In addition to the legislation that we are passing here in Congress, the administration has a crucial role to play, as do leaders at the State and local level.

We all want to end this crisis, and this common cause unites us, perhaps more than any other issue, across party and partisan lines.

Again, I thank my colleague from Pennsylvania for giving me this opportunity, and I thank him for his work in this area.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I thank my colleague and friend for his dedication on this issue. And, yes, he is right: we have to cross party lines and work on this together.

Mr. Speaker, I yield to the gentleman from Ohio (Mr. CHABOT), another friend, who has seen these problems, as well, in his district and knows full well how these problems have merged well into the Ohio area, as it is an insidious problem.

Mr. CHABOT. Mr. Speaker, I thank the gentleman for yielding and for his leadership in this most important area.

Mr. Speaker, the heroin and opioid scourge is running this country into the ground, and, unfortunately, the problem appears to be getting worse, not better. That grim reality is particularly true in my district in Cincinnati, where, during a single week last summer, city health officials reported 174 overdoses in 1 week.

Deaths caused by opioids have doubled in my district, where, during the first 4 months in 2017, the Hamilton County Coroner's Office had already logged in hundreds and hundreds of opioid overdoses—heartbreaking numbers.

But numbers only tell part of the story. The circumstances surrounding the spike in overdoses can, at times, be horrifying.

A couple of months ago, in Cincinnati, Ohio, a 9-year-old girl called 911 about both of her parents, who overdosed on heroin in their SUV. She told the dispatcher she was scared and that her parents wouldn't wake up. The girl didn't know where she was or what was wrong with her parents, but she, fortunately, knew how to call 911. That call saved her parents' lives.

But no little girl—or little boy, for that matter—should ever be placed in that situation by their parents, or by anyone.

These types of stories are becoming all too common. Opioids don't discriminate based on age or race or socioeconomic class. Opioids can kill anyone, in any neighborhood. Every day, there are more headlines about how heroin and other opioids are basically taking over the country.

The simple fact is that nearly every Member of Congress could come to the floor today and share a similar story from their own district. That is why, Mr. Speaker, it is imperative that we work together to find new and more successful ways to combat the opioid epidemic. We need to put politics aside and help people in need.

Last year, we came together in a bipartisan manner to pass the Comprehensive Addiction and Recovery Act, or CARA, and I think there is a good chance that the expanded treatment and recovery options that legislation created will help some of those suffering from addiction to turn their lives around.

While CARA will give local law enforcement and healthcare officials more resources to fight opioid addiction, we need additional legislation to help combat the importation into the United States of extremely dangerous synthetic drugs like fentanyl and carfentanil, which many have blamed for the spike of heroin overdoses. According to the DEA, much of the supply of these two dangerous drugs on our streets originates overseas, particularly from China and India.

Bipartisan legislation is being led by Representative TIBERI and Senator PORTMAN, the Synthetics Trafficking and Overdose Prevention, or STOP, Act. It would update the customs process to require that advanced electronic notice of all packages, large or small, be provided to Customs officials. Providing this information to Customs before the packages arrive will help them, meaning the Customs agency, to intercept more illegal shipments and prevent these dangerous drugs from reaching drug traffickers within our borders.

I am hopeful that this legislation will be embraced with the same bipartisan enthusiasm that we saw with CARA because the heroin and opioid problem in this country is too serious, too significant, and too widespread for us not to work together at every level of government to find a solution to this epidemic. It is way overdue. We need to work together in a bipartisan manner about this.

I again want to thank the gentleman from Pennsylvania for his leadership in this area.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I thank the gentleman from Ohio.

I point also on this map here to the Cincinnati area in southern Ohio, which is one of the hot spots in 2014 that has continued to grow as a problem. We recognize this is both a local problem and a nationwide problem.

I want to tell a story here.

Last December, when the President was signing into law the 21st Century Cures Act, which included my legislation, the Helping Families in Mental Health Crisis Act, a former State Senator from West Virginia took the stage to introduce it. David Grubb talked about his daughter, Jessie, who, herself, had been in rehab, in treatment, something like three or four times, had had several drug overdose instances and had been revived. But what happened to her also is part of what they called the loaded gun that never should have happened.

She went into the hospital for some surgery, but the doctors and nurses never told her discharging doctor that she was in recovery for heroin addiction. The point we made before about the NASPA list, or the other lists there, or the 42 C.F.R., blocks information from going into the medical record. So while someone was out to protect her privacy, they didn't protect her from death.

She was given a prescription of 50 opioid painkillers. Remember, I said before that when a person is given this prescription, they run the risk of relapse, overdose, or bad drug interactions. In her case, it was an overdose that finally took her life—another important reason why we have to deal with this 42 C.F.R. and get rid of that arcane and, quite frankly, deadly law.

Let me talk about some other recommendations of what I believe Congress can do to help.

The references made before by Dr. BUCSHON and others about the prescription drug monitoring program—and also BUDDY CARTER of Georgia mentioned this, too—where a pharmacist or a physician can say, ''Is this person on other opioids? Have they jumped across the border? Have they seen four, five, or more physicians for some opiates?'' by having a better PDMP, prescription drug monitoring program, or National All Schedules Prescription Electronic Reporting program, we have to make sure that all States use the same system and that it collects data from across borders so doctors can easily see this.

But part of this, too, in dealing with the 42 C.F.R., is understanding Federal

law prohibits including buprenorphine and methadone in the PDMP. How absurd and how cruel that is that a doctor would not even be able to know that a patient is taking one of those prescriptions.

Also, some of these drugs can end up being a respiratory suppressant, and when the patient takes another drug such as benzodiazapine, it can add to that effect and add to further complications.

Another aspect, too, which we must be further engaged with is vigorous public education programs across all age groups, beginning with early elementary school.

□ 1730

When schools have some of these programs—and we will bring forth some models that talk about these programs in a future hearing I will be holding in the Oversight and Investigations Subcommittee—these are very, very important to help students, early on, understand the dangers of this.

This is not just recreation, but it is so easy to slip into addiction. Given that 80 percent of drug abuse begins with a prescription, whether it is a student, athlete, perhaps a football player who injures a leg or something and he is given some of these drugs, it is essential the whole family be counseled from the onset, understanding the concerns and dangers of continuing to take these drugs.

We also have to have drug take-back programs and public education programs stressing the importance of proper disposal of unused opiates and pain prescriptions to prevent them from being stolen or misused. For example, if a family is selling their home and they are having an open house and strangers come into the house and while they are there they say, ''Can I use your restroom?'' and the family lets them do that, don't be surprised if that person has no intention of buying a house but does have an intention of going into the bathrooms and checking the medicine cabinets and finding any medication and taking it.

Also, when teens come over to the house for parties or socializing, don't be surprised if they also go into medicine cabinets, look in drawers in the bathrooms or drawers in other places of the house looking for some of those drugs which they, themselves, will take or sell.

We have to make sure we have vigorous patient education programs about doctor-prescribed opioids to make sure people know about that before the addiction takes foot. And taking one of these prescriptions may only take 3 or 4 weeks before it begins to kick in and cause problems.

I know myself, back in 2005, I was in a rollover accident in Iraq with a couple of other Members of Congress. Our vehicle rolled, and as a result of that accident, I ended up having a mild concussion, snapping my neck, having some temporary paralysis, and a great deal of pain. Well, battlefield medicine is one that gets you out of the area, stops the bleeding, stops the pain, and ships you off to some other hospital, and that was the case for me.

But I know what happens. Everywhere I landed in a helicopter or an ambulance, appropriately so, the physicians would ask me a number of orienting questions, but also say: ''Are you in pain? On a scale of 1 to 10, how much pain are you in?'' And when I proceeded to say that number, immediately, as they would do for many other people in the battlefield, they would administer morphine or some other pain reliever and move you on from there.

What happened, though, returning to the United States, where pain continued for me, I was prescribed some pills for that pain, but I was also prescribed fentanyl. Never once was it ever described to me: ''Be careful with this. This is highly addictive. This is a problem.''

Now, after a few weeks on this and recognizing it was hard to even do my job because I couldn't keep my head clear, I just said: ''That it is. I am not taking this anymore.'' But at that point, my body had already begun to develop some tolerance for this, and when I stopped taking it, I had some reaction.

Granted, it was not as severe as some of those who have been taking these drugs at a higher dosage and longer, but I could feel myself actually saying I understand what people mean when they say their skin feels like it is peeling off of them and they feel a sense of nausea and other problems as well.

Now, I can't even imagine what it is like for someone who is taking higher doses for longer periods of time. But it is extremely important that, every time a prescription is written, pharmacists have an opportunity to counsel patients and doctors are also doing more than simply passing out a prescription.

Pharmacists should do what BUDDY CARTER was saying before: make sure they have the person showing a photo ID. Is this, indeed, a prescription they are picking up for themselves or claiming they have it for someone else? Perhaps that prescription was stolen from someone.

We have to make sure that we also understand, for those out there trying to legalize marijuana, I caution you, because the marijuana that is out there on the streets or presented in many areas can cause tremendous psychiatric problems for those who are already at risk. The longer you are on some of the types of marijuana, the greater risk you have for things like delusional behavior.

We have to make sure we also eliminate Medicaid payments for those question 14 responses I made reference to before when you are in the hospital to ask if the hospital adequately addressed your pain.

In the area of treatment and recovery, we have to expand the mental health workforce. As I said before, half the counties in America have no psychiatrists, no psychologists, no drug and alcohol counselors, and those who are out there likely have their schedule so filled, they don't even have room to treat someone. Not all of them even know how to treat addictive disorders.

The fact that a majority of people who may have an addiction disorder also have a concurrent mental health disorder is another reason why we have to increase this workforce by tens of thousands. Just for child and adolescent psychiatrists alone, we need another 21,000 of those.

We need tens of thousands more psychologists. It is important that the schools of medicine, schools of psychology, and schools of social work are graduating more people with these degrees and getting them into our workforce.

I have had legislation before, and we passed some things in the 21st Century Cures Act and in my Helping Families in Mental Health Crisis Act, to provide more funding so that more of these folks can continue with their education. It is essential. It is like trying to fight a war without soldiers, trying to fight this war, which is killing more people every year than the entire war in Vietnam, but we do not have the soldiers to fight this.

We also have to make sure that, with regard to the government-sponsored medication-assisted treatment which I referred to before, we cannot simply rely on synthetic opioid maintenance alone. We have to make sure there are requirements to have that person in counseling and treatment.

I have heard from some persons that go to those treatment programs that they have no counseling at all, and some have great counseling. In some cases, sitting in the waiting room, perhaps a nurse or someone simply checks up on them: ''What are you doing? How are you doing?'' That is considered and written down as group therapy. That is not acceptable in any way, shape, or form.

We need 100,000 more inpatient psychiatric beds, and we have to make sure insurance companies recognize that an addictive disorder is a chronic disorder. Simply giving someone a weekend or a few days for withdrawal and then putting them back on the street is not an answer.

That is why we have to encourage private insurance companies and Medicaid and Medicare. And I say Medicare because a large number of people who are having some of these problems are also the elderly.

We have to make sure that we increase the availability of fast-acting opiate blockers for first responders, such as Narcan. But let's keep this in mind: In some cases, we hear of some of those pushers of these drugs who also give an accompanying dosage of Narcan, recognizing that the drug will bring that person to a near-death experience.

We have heard from first responders and others, law enforcement, where someone may actually have a party where someone will remain there expecting that someone will actually have an overdose and die in order to bring them back to life. That is how some of these people are seeking some of those experiences.

We have to make sure that States review their laws, as some are doing, that if you take one of these opiates and you do have that near-death experience, perhaps that should be treated the same as a suicide attempt, that that person is in imminent danger of harming themselves or someone else and perhaps determine if they need an inpatient psychiatric stay.

We have to make sure we have support of employment for those in recovery to break the cycle of recovery and reexposure. Many times, persons who are trying to stay clean, they can't get a job because they can't pass the drug test, so they may be in a job and have exposure to other people who still end up with substance abuse.

We have to make sure they have higher standards and increased accountability for payment models that require evidence-based treatment in halfway houses, three-quarter houses, and residential treatment facilities.

We have to deploy certified addiction counselors to emergency rooms because we know that, when a person comes to an emergency room, if they see an addiction counselor there, they are not just simply given a business card and told, ''Call someone next week and we hope you get treatment''; but if they see an addiction counselor in the emergency room, they increase their chances of follow-up by 50 percent, according to a Michigan study.

We must make sure the FDA is working with companies to find alternatives to opioids and that, again, Medicaid and other physicians are educated on some of those aspects.

Physician training has to also be ramped up: require them to have training in opioid prescribing practices on risk for addiction and abuse and prescribing limited dosages. Instead of prescribing dosages for a month, perhaps just a couple of days. In many cases, they are not adequately trained in alternatives to opioids and the potential harm of overprescribing.

We have to increase training requirements for healthcare providers who deliver this medication-assisted treatment. Right now, in many cases, they only have a few hours of training, and then they can go and prescribe this and have very little, if any, training at all in drug addiction counseling. Before doctors write a prescription, we can make sure they are looking at the NASPER list or other lists as well.

In the area of law enforcement, it is critical that what is called the High Intensity Drug Trafficking Areas program is made more available, with greater access around the country.

Mr. Speaker, how much time do I have left in our segment here?

The SPEAKER pro tempore (Mr. HOLLINGSWORTH). The gentleman has 7 minutes remaining.

Mr. MURPHY of Pennsylvania. We have to make sure we have more border security so that we are intercepting these drugs as they come across the border.

We need funding for the post offices because, in many cases, unwittingly, the letter carriers are the ones who are delivering to people's homes fentanyl and other drugs.

In the incarceration system, we have to make sure we are testing inmates for the presence of drugs in their system during their incarceration. We can offer them medications which, upon discharge, actually block any effects of some of these drugs.

We need to also make sure that Medicaid and other insurance companies' payments resume immediately upon release from their incarceration to prevent them from relapsing or returning to the drug culture.

We also have to make sure we have solid data collection. In many cases, when we show the charts about death rates around the country, the charts may be grossly inaccurate. In many cases first responders, paramedics, and coroners do not keep accurate data on these rates. The persons themselves may not even be tested to see if they died from a drug overdose.

There are several items in here listing what we can be doing here as a nation, and there are many more. The point is we have fallen short and we have seen some problems with this. There is more that we can do and we must do in order to save lives.

I know I just have about 3 minutes left, Mr. Speaker, am I correct?

The SPEAKER pro tempore. The gentleman has 5 minutes remaining.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I yield to the gentlewoman from Ohio (Ms. KAPTUR) to talk about some of the issues dealing with substance abuse.

Ms. KAPTUR. Mr. Speaker, I thank Congressman MURPHY for his incredible leadership on this important topic and for holding this Special Order this evening.

I can tell you, the citizens of the State of Ohio are paying attention. The opioid epidemic continues to intensify with over 2 million people addicted to prescription opioids and more than half a million addicted to heroin in 2015, alone.

According to an estimate from The New York Times, drug overdoses are now the leading cause of death for Americans under 50; and drug overdoses are the leading cause of accidental death in our country, with prescription opioids responsible for more than 20,000 deaths in the United States just in 2015, according to the American Society of Addiction Medicine.

I have to mention that Medicaid plays an important role in addressing this epidemic because it is a lifeline program, providing coverage to over 650,000 non-elderly adults with opioid addiction and covering a range of treatment services.

Ohio, tragically, leads the Nation in opioid overdoses in 2014. Sadly, deaths have continued to rise with increased use of heroin and fentanyl. Many States have expanded Medicaid, including Ohio, to cover adults who make a modest $16,500 a year per individual. By broadening coverage of adults, the Medicaid expansion reaches many low-income adults with opioid addiction who were previously ineligible for coverage and facilitates access to treatment.

The opioid epidemic is so bad that even librarians are learning how to treat overdoses for individuals who come into libraries.

Mental health can be comorbid with opioid abuse, and those suffering from that duality are truly an American tragedy. For an addict to complete rehab and recovery successfully, they need to work in concert. And over half of uninsured non-elderly adults with an opioid addiction had a mental illness in the past year, with over one in five operating with a serious mental illness, such as depression, bipolar disorder, or schizophrenia.

To address the gravity of the challenge, I want to put on the RECORD the work that Lucas County, my home county, is doing with their DART program, which engages hospitals, mental health centers, and businesses in the community.

Believe it or not, according to Sheriff Tharp, the DART program has helped nearly 2,300 overdose victims and has a 74 percent success rate of getting people into detox and treatment programs at a total cost of about $370 per individual. This is truly an amazing record, and I wish to include in the RECORD the information about other counties in the district that I represent.

The opioid epidemic does not just affect the addicted. Lucas County Children Services is struggling to help children displaced by the opioid epidemic.

The agency has been repeatedly forced to do the unimaginable tasks of comforting children as first responders work to save their parents from a heroin or fentanyl overdoses. On several occasions, it has had to break the terrible news to these children that their parents succumbed to their addiction.

LCCS is also coping with a dramatic increase in the number of children placed in protective custody because their families have been blinded by substance dependence. The State's current budget proposes no increase for this program, which is a shame. This is no time to short change children.

Finally, I submit for the RECORD a story of the Guest family of Lorain, Ohio, whose daughter Tera died of a heroin overdose at the age of 24.

According to the Cleveland Plain Dealer: ''Tera Guest, 24, died Jan. 29, 2014, shortly after she and her sister used painkillers and a heroin-fentanyl mix. Her death marked the end of a two-year period that included stints in treatment and losing custody of her two children to her mother.

"Tera is among the hundreds who have died of overdoses within the last three years in Lorain County. The county coroner's office said a record 67 people died in 2013, followed by 60 in 2014 and 62 in 2015."

Lori took her tragedy and turned it into action and formed the Lorain Community Task Force, which is a group that raises awareness and provides assistance to addicts and their families.

Lori stepped up, and now Congress must do the same. We cannot turn our back on these people now. We must fight, we must work together, we must put politics aside. Only then can we begin to heal our Nation from this crisis.

Mr. MURPHY of Pennsylvania. Mr. Speaker, I yield to the gentleman from Wisconsin (Mr. GALLAGHER).

Mr. GALLAGHER. Mr. Speaker, I thank the gentleman for yielding and for his leadership on this critical issue.

As was laid out, communities across this country, communities like mine in northeast Wisconsin, are in the midst of a public health crisis. It is not a Republican or a Democratic issue. It is an American issue, one that should bring us all together.

Opioid abuse is wreaking havoc on our homes, our schools, our churches. Its devastating effects are destroying our families and the lives of our loved ones.

As was pointed out, more Americans will have died from drug overdoses in 2017 than there are names on the Vietnam War Memorial. That is alarming. That should put it into sharp relief.

As a Marine veteran, I am acutely aware that servicemembers are more susceptible than the average person to addiction. In fact, veterans die from accidental drug overdoses at a 33 percent higher rate than the rest of the population, and something must be done to reverse this awful trend.

I commend our State lawmakers in Wisconsin who are doing aggressive work on this front, and I commend the gentleman and everyone who has spoken out for doing the same thing at the national level, and I look forward to working with him.

Because headline after headline reminds us of the tragic loss of life that has resulted from our Nation's opioid and addictions risk, we have to step up. We have to take action.

Mr. MURPHY of Pennsylvania. I yield to the gentleman from Oregon (Mr. BLUMENAUER).

Mr. BLUMENAUER. Mr. Speaker, I deeply appreciate the gentleman convening this Special Order this evening. It has been fun working with him in the past on creative, bipartisan efforts to try and make sure the Federal Government is a better partner on this.

I look forward to working with him on legislation that will make it easier to be able to have the information available that people need for integrated treatment and his commitment to trying to bring people together to understand the problem and the fact that we are agreed more than we are divided on these things. I look forward to working with him on some progress in the months ahead.

□ 1745

Mr. MURPHY of Pennsylvania. Mr. Speaker, I thank my friend from Oregon, and I thank all the Members speaking here tonight. I want to say, as you saw, this was a bipartisan coalition of Members. We are much better off working hand in hand to pass legislation that changes issues than standing next to each other as pallbearers for another 59,000 people in our Nation next week.

Mr. Speaker, with that and with some hope that we can pass this legislation and save some lives, I yield back the balance of my time.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 3003, NO SANCTUARY FOR CRIMINALS ACT

Mr. COLLINS of Georgia (during the Special Order of Mr. MURPHY of Pennsylvania), from the Committee on Rules, submitted a privileged report (Rept. No. 115–195) on the resolution (H. Res. 414) providing for consideration of the bill (H.R. 3003) to amend the Immigration and Nationality Act to modify provisions relating to assistance by States, and political subdivision of States, in the enforcement of Federal immigration laws, and for other purposes, which was referred to the House Calendar and ordered to be printed.

REPORT ON RESOLUTION PROVIDING FOR CONSIDERATION OF H.R. 3004, KATE'S LAW, AND PROVIDING FOR PROCEEDINGS DURING THE PERIOD FROM JULY 3, 2017, THROUGH JULY 10, 2017

Mr. COLLINS of Georgia (during the Special Order of Mr. MURPHY of Pennsylvania), from the Committee on Rules, submitted a privileged report (Rept. No. 115–196) on the resolution (H. Res. 415) providing for consideration of the bill (H.R. 3004) to amend section 276 of the Immigration and Nationality Act relating to reentry of removed aliens, and providing for proceedings during the period from July 3, 2017, through July 10, 2017, which was referred to the House Calendar and ordered to be printed.

ISSUES OF THE DAY

The SPEAKER pro tempore. Under the Speaker's announced policy of January 3, 2017, the Chair recognizes the gentleman from Texas (Mr. GOHMERT) for 30 minutes.

Mr. GOHMERT. Mr. Speaker, I thank all my fellow Members that are speaking up on this very important issue. I appreciate Dr. Murphy taking the lead. It is something that has not gotten enough attention. We continue to have people dying, and we need to deal with the issue.

It is interesting: some people find great hope in their religious beliefs. Throughout America's history, Christianity has been an important foundation. No, you didn't have to be a Christian to participate in government, to be a Founder, but, as Ben Franklin said, we know because he wrote out the speech in his own handwriting immediately afterwards, as requested.

So often, teachers teach that he is a Deist, as so many of the Founders, we are told, were Deists. Yet in his own words, in his own handwriting, at the Constitutional Convention in 1787, at 80 years old, 2 to 3 years away from meeting his Judge, his Maker—severe gout, arthritis, overweight, trouble getting up and down—he said these words:

''I have lived, sir, a long time, and the longer I live, the more convincing proofs I see of this truth—that God governs in the affairs of men. And if a sparrow cannot fall to the ground without His notice, is it probable that an empire can rise without His aid?''

Franklin said, we have been—by the way, that is obviously a reference to Jesus' comment about the sparrow, and God seeing the sparrow, watching the sparrow.

But he goes on and he makes it very clear, as his own words indicate, that unless—he said: ''We have been assured, sir, in the Sacred Writing that except the Lord build the house, they labor in vain that build it.''

Again, referencing Scripture.

Those are not the words—any of them—they are not the words of a Deist. So teachers that have been miseducating people for so long, I know they are just passing on what they were taught, but there has been so much miseducation for so long.

Regardless of what else, we don't try to force our religious beliefs on anyone. That is not what the House of Representatives is for. But since it formed such an important part of our founding and a part of the discussion for most of our Nation's history, it is important to point out that those Scriptures that Ben Franklin referenced at the Constitutional Convention, the Scriptures that have been quoted so often—

We know the Bible is the number one, far and away, most quoted book in the House of Representatives and the Senate. Nothing else anywhere even close. It has brought hope to people that had no hope.

So it is interesting that, as our Nation moves further and further away from the source of so much hope for so much of our Nation's history, and for those who lived through that part of our Nation's history, the hope that Franklin Roosevelt brought to the microphone when he read the famous prayer on D-Day as American soldiers were fighting, as he said, against those forces of evil, drawn from a country that was used to peace that were fighting forces of evil.

But they had hope. That hope and prayer that Franklin Roosevelt gave over the microphone for several minutes now is condemned by so many.